

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017777

FILED MAY 21 1959

Registration District No. 149 Primary Registration District No. 10025 STATE FILE NUMBER Registrar's No. 2080

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CLEVELAND</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NEUROLOGICAL HOSP</u>		Length of stay in 1b <u>2 MOS 4 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>019</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>H.</u> Last <u>Jacobs</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1959</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (City and state or country) <u>South English, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Perry Hennon</u>		13b. MOTHER'S MAIDEN NAME <u>Alma Glandon</u>	14. NAME OF HUSBAND OR WIFE <u>Alva Jacobs</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>D. J. Jacobs Cleveland, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERAL ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>+10 YRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			<u>334X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>FEB 22 1959</u> to <u>APRIL 26 1959</u> and last saw <u>him</u> alive on <u>APRIL 26, 1959</u> Death occurred at <u>6:40 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Albert E. Fulton M.D.</u>		22b. ADDRESS <u>2625 W. Paseo, Kansas City, Mo</u>	22c. DATE SIGNED <u>4/26/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>April 28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellevue</u>	23d. LOCATION (City, town, or county) (State) <u>2 MI South Cleveland MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Rev. E. Myers Cleveland Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-26-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Albert E. Fulton USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Geo. E. Myers* .....

Licensed Embalmer No. *2517* .....  
P. O. Address *Cleveland, Mo* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.